341 Patients' preferences of medical information

K. Strandner[1], M. Gilljam[2]. [1]Sahlgrenska Academy, Göteborg University, Göteborg, Sweden; [2]Sahlgrenska Academy, Göteborg University, Respiratory, Göteborg, Sweden

Objectives: To assess patients' preferences of medical information.
Methods: Patients attending the Gothenburg adult CF centre undergo a comprehensive yearly assessment. At the follow-up visit the results are discussed and a treatment plan for the next year is agreed upon. In addition to verbal information a mailed copy of the written medical chart note is offered. As this information may be difficult to understand and the crucial points get lost we have recently added a handwritten short note outlining the most important results and treatment plans. This handwritten note has the advantage of being co-written with the patient at the visit. A brief questionnaire is employed to evaluate patients' preferred mode for medical information. The handwritten note, received at the visit, was preferred by 25/46 (54%) and a mailed copy of the medical chart note by 13 (28%) of the patients while 6 (13%) patients were content with verbal information only. There was no difference for gender, FEV_1% predicted, age or pancreatic function. Regarding general disease information and education 11/46 patients preferred individual education at clinical visits, 4 group education, 6 written information and 16 patients preferred internet-based information. 8/46 did not need any information (and one patient listed all alternatives as preferred).
Conclusion: It is important to complement verbal information of test results and treatment plans with written information and this can be individualised according to the patient's preference.

342 Therapeutic patient education and quality improvement program: What synergy?

V. David[1], G. Rault[2], D. Pougheon-Bertrand[2], E. Dorenlot[2]. [1]University of Nantes, Paediatric CRCM, Nantes, France; [2]University of Nantes, Nantes-Roscoff, France

Objectives: Therapeutic patient education (TPE) is a patient centered care approach which is, according to a structured process from diagnosis to adult care transition, proposed to all patients and families in our paediatric center since 2006. Finality of TPE is to improve quality of life by acquisition or maintenance of self-care and psychosocial skills. Our center participates in the French CF QIP since 2011 and is focused on deepening links between TPE and QIP.
Methods: CF QIP in France is modelling the US-CFF Quality Improvement initiative. The first step is a 5Ps diagnosis of our center (Purpose, Patients, Professionals, Process, Patterns). We noticed that median FEV1 in our center for patients aged 12–18 was close the worst in French Registry. We decided to improve it. Our "fishbone" showed we had to pay more attention to "body image" in adolescents and to the outpatient visit process. We set up a dashboard of "Metrics That Matters" including number of patients who: attended TPE sessions; regularly practise exercise; use an exacerbation action plan; have been proposed art-therapy and realised it; filled out a quality of life-anxiety-coping-depression questionnaire. Each Metric and its goal were assigned to a professional of the multidisciplinary team Our team chose to use the TPE approach in this adolescent population to reach the set up goals. Actually, TPE is based on the patient's project and reinforces self-esteem and self-confidence which are essential to support the development of long term care and coping skills.
Conclusion: TPE and QIP are two synergistic patient centered approaches especially in a chronic illness like cystic fibrosis.

343 A survey to assess patients' perceptions of CF psychosocial and nursing care during the process of lung transplantation

A. Prosser[1], C. O'Leary[1], A. Mcculloch[1]. [1]University Hospital Llandough, All Wales Adult CF Service, Vale of Glamorgan, United Kingdom

Objectives: Increasing numbers of patients under the care of the All Wales CF Service are undergoing lung transplantation. During the process patients receive routine care from the CF Service. However, research evidence suggests they might benefit from increased nursing and psychosocial care. In order to develop a structured care pathway we surveyed post-transplant patients about the current service and ways in which it might be improved.
The survey was designed to measure the number of patients who accessed psychosocial/nursing support, what other input would have been helpful, whether they had enough information about transplant beforehand and what ideas they had for improving support.
Methods: All surviving CF patients who had undergone lung transplantation in the last 3 years (n = 7) were contacted by telephone and a link was sent by email to complete the survey online, which consisted of 19 closed option questions and 11 open ended questions.
Conclusion: A total of five people responded. 100% had seen the CF psychologist and received support from the specialist nurses. One person felt they had not been given enough information about transplant. 100% felt they had received enough care from the CF service whilst on the waiting list. 80% felt they would have benefited from seeing a CF team member at the transplant centre following transplant. 60% felt they needed more support after their return home, with one person feeling 'abandoned'. 100% would have found it useful to speak to other CF patients about their experiences of transplant. These findings will help us to improve our care of patients during the transplant process.

345 Systematic review of qualitative studies investigating barriers to adherence in patients with cystic fibrosis using framework analysis structured by a conceptual framework of behaviour change

S. Jones[1], R. Curley[2], M. Wildman[2]. [1]Sheffield Teaching Hospital, Department of Psychological Services, Sheffield, United Kingdom; [2]Northern General Hospital, Adult Cystic Fibrosis Centre, Sheffield, United Kingdom

Objectives: Effective interventions to increase adherence will usually be multifaceted. The Medical Research Council advocates the use of a conceptual framework to structure such interventions. Horne's classification (Clifford J psychosom Res 2008) of non-adherent patients into those who won't and those who can't adhere maps to Michie's generic Capability, Opportunity and Motivation (COM-B) model (Michie Implement Science 2011) and COM-B maps to a taxonomy of interventions. We used this model to classify adherence barriers in a systematic review of adherence in CF.
Methods: A systematic search identified 7096 studies of which 11 qualitative studies were appropriate for the review. Framework analysis using COM-B model along with Horne's can't/won't classification was used to classify barriers to adherence using framework analysis.
Conclusion: 6 major themes of barriers were identified:
1. Lack of treatment opportunity.
2. Effect of physical health and symptoms.
3. Lack of support.
4. Forgetting.
5. Treatment concerns.
6. Treatment necessity.

Barriers identified in the 11 qualitative studies were readily mapped to the conceptual framework. For example a number of studies identified patients who had chosen not to take treatment because of barriers arising from reflective motivation around perceptions of the necessity for treatment or their concerns about the consequences of treatment. (Won't take treatment) Other patients were motivated to take treatment but were unable to do so because of barriers arising from capability and opportunity (can't take treatment). These data support the usefulness of the conceptual framework in designing adherence interventions.